

Chart Number: _____

Date: _____

Demographic Form

Name

Last First Social Security Number Date of Birth

Address

Street City State Zip

Sex	Race	Language	Contact Preference	Day Phone
<input type="checkbox"/> Male	<input type="checkbox"/> African American	<input type="checkbox"/> English	<input type="checkbox"/> Cell Phone	() -
<input type="checkbox"/> Female	<input type="checkbox"/> Asian	<input type="checkbox"/> Haitian-Creole	<input type="checkbox"/> Don't Call Home	
	<input type="checkbox"/> Haitian-Creole	<input type="checkbox"/> Spanish Other	<input type="checkbox"/> Don't Call Work	Cell Phone
	<input type="checkbox"/> Multi-Racial	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Don't Leave Message	() -
	<input type="checkbox"/> Native American		<input type="checkbox"/> Home Phone	
	<input type="checkbox"/> Other	Ethnicity	<input type="checkbox"/> Leave Message on Cell	Other Phone
	<input type="checkbox"/> Pacific Islander	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Leave Message on Home	() -
	<input type="checkbox"/> Unknown	<input type="checkbox"/> Non-Hispanic	<input type="checkbox"/> Other: _____	
	<input type="checkbox"/> White		<input type="checkbox"/> Work Phone	

Email Address *(optional)*

By entering your email address, you agree to receive promotional and advocacy messages. Your address will remain confidential and never shared.

Insurance Status

Private Public Uninsured

Your answer will not affect the cost of services. This information will be used to help us better understand our customers' needs.

Family Income

Your answer will not affect the cost of the services. This information is used internally to help us better understand our customers' needs.

Family Size: _____ Income: \$ _____ weekly / monthly / annually (please circle one)

Student Status Full Time Part Time

Emergency Contact Information

Who should be contacted in the event of a medical emergency? If you are under 18, this must be the name of your parent or legal guardian. Confidentiality may be broken if we cannot contact you when a life threatening condition is suspected or detected.

Name _____ Relationship _____ Phone Number _____

The following person(s) are authorized to pick up supplies and/or birth control on my behalf (optional)

Name(s) _____

How did you learn about us?

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Employee Referral | <input type="checkbox"/> Flyer | <input type="checkbox"/> Friend/Neighbor Referral | <input type="checkbox"/> Health Fair |
| <input type="checkbox"/> Newspaper Ad | <input type="checkbox"/> Other Professional Referral | <input type="checkbox"/> Patient Referral | <input type="checkbox"/> Physician Referral |
| <input type="checkbox"/> Radio Ad | <input type="checkbox"/> Web Search | <input type="checkbox"/> Yellow Pages | |

- All Information Provided Remains Confidential -

